providers. It would also create a Medicare Provider Ombudsman to help physicians and other providers to address confusion, lack of coordination, and other problems or concerns they may have with Medicare policies.

Our bill reforms the Medicare contracting processes by consolidating the contracting functions for Part A and Part B of Medicare, permitting the Secretary to contract with separate Medicare Administrative Contractors to perform discrete functions, making use of the Federal Acquisition Rules in contracting, eliminating the requirements for cost contracting, and expanding the kinds of entities eligible for contracting. Our bill would permit consolidation of claims processing with fewer contractors, and it would permit separate contracting along functional lines—for beneficiary services, provider services, and claims processing.

Mr. Speaker, my support for combining the administrative contracting functions of Part A and Part B in no way implies my support for combining the Part A and Part B trust funds or otherwise combining the financing or benefits. I strongly oppose such a consolidation.

Mr. Speaker, I have tried for years to get CMS/HCFA to institute a single toll-free phone number for Medicare beneficiaries like the single toll-free phone number that Social Security has operated for years. Finally, in the BBA, the Congress mandated the establishment of a toll-free number, 1–800–MEDICARE. By all accounts, it has been a great success, and even CMS/HCFA now touts its success. However, CMS/HCFA has still been unwilling to permit Medicare beneficiaries to use this number as a single entry point to Medicare. The latest national Medicare handbook includes 14 pages of telephone numbers for beneficiaries to call with specific questions! Surely, if a beneficiary calls the 1–800–MEDICARE number, their call could be transferred to the appropriate number, rather than asking them to try to locate the correct number themselves from among 14 pages of numbers!

In addition to not having a single place to call for Medicare problems, beneficiaries also have no casework office whose responsibility is to help them with their Medicare problems. In the past, CMS/HCFA has relied on the contractors, but many of the problems beneficiaries face are with the contractors themselves. In addition, CMS/HCFA now relies on State Health Insurance Counseling and Assistance Programs (HICAP) organizations to help beneficiaries. I am a strong supporter of these organizations; however, these agencies are staffed with volunteers. It is absurd for a huge public program the size of Medicare to rely on volunteers to be the main source of assistance for its beneficiaries.

We should look to the Social Security Administration to identify ways to provide assistance for Medicare beneficiaries. For example, Social Security not only has regional teleservice centers to staff their national toll-free line and help beneficiaries with their questions, SSA also has Program Service Centers to perform casework for Social Security beneficiaries with specific problems. We need similar offices for Medicare beneficiaries to perform casework for them. Currently, Medicare casework is handled primarily by Congressional offices, since no casework office exists in Medicare.

I have proposed that Medicare staff be stationed in Social Security field offices to help answer questions and provide assistance for Medicare beneficiaries. There are 1291 SSA field offices around the world, and I would like to see Medicare staff in many, if not all of them in the near future. I am pleased that the legislation we are introducing today authorizes a demonstration program to examine the value of placing Medicare staff in SSA field offices, and I hope it will be expanded if it is found to aid beneficiaries.

Finally, Mr. Speaker, let me address Medicare administrative resources. Two years ago, in the January/February 1999 issue of Health Affairs, fourteen of our nation's leading Medicare policy analysts—ranging from conservative to liberal—published an open letter titled, ''Crisis Facing HCFA & Millions of Americans.'' The crisis they spoke about was the lack of resources to administer Medicare. Their letter is even more relevant today. As its administrative workload has increased, CMS/HCFA resources have not kept pace. The changes that we propose in our legislation today are important, but by themselves, they are not sufficient. We simply must get more resources into Medicare administration.

PERSONAL EXPLANATION

HON. ASA HUTCHINSON

OF ARKANSAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 2, 2001

Mr. HUTCHINSON. Mr. Speaker, I was inadvertently detained during several rollcall votes this week. If I had been present I would have voted in the following way: Rollcall No. 301—''yea''; No. 302—''nay''; No. 304—''yea''; No. 305—''yea''; and No. 320—''yea''.

TRIBUTE TO THE HONORABLE WILLIAM E. LEONARD

HON. GARY G. MILLER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 2, 2001

Mr. GARY G. MILLER of California. Mr. Speaker, I rise to pay tribute and honor the accomplishments of The Honorable William E. Leonard, member of the California Assembly, 63rd District.

Mr. Leonard earned a bachelor's degree in Business Administration from UC Berkeley in 1944, and served in the United States Army from 1943 to 1946 where he rose to the rank of First Lieutenant. After his military service, he joined his father at the Leonard Realty & Building Company. He served as a member of the California State Highway Commission from 1973 to 1977, and was appointed to the California Transportation Commission from 1985 to 1993, and served as its chair in 1990 and 1991. Prior to that he was a member of the state's Athletic Commission from 1956 to 1958. He currently serves on the state's High-Speed Rail Authority.

Mr. Leonard has been actively involved in a number of community organizations. He is a member and past director of the San Bernardino Host Lions, a founding member and president of Inland Action, Inc., and a member of the National Orange Show Board of Directors, where he has served as President and Chairman of the Board of Governors. He is also a member and elder of the First Presbyterian Church of San Bernardino. He served on the San Bernardino Valley Board of Realtors, San Bernardo Valley Foundation, St. Bernadine's Hospital Foundation, and the University of California at Riverside Foundation.

In recognition of his outstanding service to the constituents of the 63rd Assembly District, and his involvement in bringing the Foothill Freeway to the Inland Empire, the California State Senate passed a resolution naming the interchange of I–15 and Route 210 as the William E. Leonard Interchange. A dedication ceremony will take place on July 20, 2001.

Mr. Leonard's exemplary record of service has earned the admiration and respect of those who have had the privilege of working with him. I would like to congratulate him on these accomplishments and thank him for the service he has provided to his community.

IN RECOGNITION OF THE COMMUNITY ACTION COUNCIL OF SOUTH TEXAS

HON. CIRO D. RODRIGUEZ

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 2, 2001

Mr. RODRIGUEZ. Mr. Speaker, today I would like to recognize the important contributions of the Community Action Council of South Texas (CACST) to the improvement of the general quality of life of the citizens of South Texas. CACST is a private, nonprofit corporation that provides high quality comprehensive primary health care to the medically underserved residents in Duval, Jim Hogg, Starr, and Zapata Counties in South Texas. These counties are currently medically underserved due to geographic isolation, financial barriers, and an insufficient number of health care providers.

The CACST has made great strides in the South Texas health care system, specifically by empowering communities to develop programs to meet their specific needs. This has strengthened the local communities and enhanced opportunities for children and families. In addition, the CACST has maintained a high standard of accountability and provided health care services in accessible low-cost environments.

They have worked to improve access to quality health care by providing trained professionals in areas that had previously been underserved and promote individual responsibility and health awareness in the communities. It is critical that the CACST remain a provider of primary health care and their host of support services, including transportation, case management, outreach, and eligibility assistance. Their presence in the South Texas community has been a tremendous benefit to the individuals that reside there. I commend their efforts to help achieve primary health care for everyone and end health disparities.